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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIF	PLE CONSTRUCTION		SURVEY
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
AND THE PROPERTY OF THE PROPER		525 SOU	TH MACON	STREET		
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(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE
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5 000	Initial Comments		S 000	TO THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OW		
			or contrasts of			
	First Probationary L	icensure survey	Approximate the second			
			* Constitution			
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:	·			
	Disaster Preparedn	ess				
			Paris and Paris			
		c)3), 300.670d) and 300.670k)	District the control of the control			4
1	1), 2), and 3)		MANAGEMENT OF THE PROPERTY OF			
Fire drill shall be held at least quarterly for each		store agent				
		nnel. Disaster drills for other	-			
ormani e	than fire shall be he	ld twice annually for each shift	And the second s			
		Drills shall be held under	and the same of th			
		evaluate the effectiveness of	Company of the Compan			
		rocedures. Fire drills shall				
		f the evacuation of residents				
		at least one drill each year				
A CONTRACTOR OF THE CONTRACTOR		ually, each facility shall				
		disaster policies and plans				
		Section to the local health				
		mergency management				
		liction. Annually, each facility				
		of its emergency water				
		required under Section				1
		ocal health authority and local		Permittan		I
	emergency manager					l
	jurisdiction. Each fa					[
		ergency source of electrical		Account of the control of the contro		1
		services connected to the				
		nealth authority and local		min at the state of the state o		
		y having jurisdiction. The		Attachment A		***************************************
		ne local authority and local				
		ment agency at any time that		Statement of Licensure V	iolation	S
		ce of power or services		Affillatif At Staatlagia a	. w . w. as a	-
	connected to the sou	irce are changed.				I
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
IL6012322		B. WING		09/	10/2015	
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	These Requirement	ts were not met as evidenced				
	by the following:	is word not met as evidenced	The state of the s			
	•					
	Based on record rev	view and interview, the facility				:
	failed to conduct two	o fire drills on the night shift	State of the state			
	and one tire drill on	each of the day and the				No.
	failed to conduct one	st complete four quarters;				
failed to conduct one disaster drill on the day shift, one disaster drill on the evening shift, and two disaster drills on the night shift in the past						
year; failed to conduct an evacuation drill for each shift in the past year; failed to evaluate the personnel performance and effectiveness during			777711111111111111111111111111111111111			
	disaster plan, emerg	rovide copies of the facility's				
	source of emergence	pency water plan, and the y power to the local health				
	authority and local ei	mergency agency. This has				
	the potential to affect	t all 34 residents in the				
	facility.	all the control of th				
		Polycrome				
	Findings include:	TO CANA A TOPO OF THE TOPO OF				
	Fire and disaster drill	I records for the last four				
		uly 2014 to June 2015)				er denne de la companya de la compan
	indictae one fire drill	was not conducted for the				
1	third shift (10:00 P.M	I. to 6:00 A.M.) during the				
		4 and the first quarter of				
	2015, for the first shi	ft (6:00 A.M. to 2:00 P.M.)	The state of the s			
	curing the second qu	uarter of 2015, and for the M. to 10:00 P.M.) during the				
,	second shift (2,00 F.)	15. The disaster drills were				
ì	not conducted for the	e first shift or for the second				
		rills were not conducted for				
	he third shift.	and the state of t	1		90 000	
		The state of the s				
		not found that the facility had				
	conducted any evacu	ation drills or evidence that				
f	in evacuation driil wa ire or disaster drill.  N	as not conducted as part of a				Company
		conducted to move residents				
		- I I I I I I I I I I I I I I I I I I I	1			

Illinois Department of Public Health

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6012322 09/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **525 SOUTH MACON STREET MOWEAQUA REHAB & HCC** MOWEAQUA, IL 62550 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 to a safe area. The fire and disaster drills records did not have any evaluation of the effectiveness of the drills. the response of the staff, or comments any issues or concerns that had developed. E1, Administrator was interviewed on 9-9-15 at 9:50 A.M. regarding the absence of the drills and documentation. E1 stated what was reviewed is the only thing E1 could find. E1 stated that E1 could not find evidence that the facility's disaster plan, emergency water plan and the source of emergency power was given to the local health authority and local emergency agency. On 9-8-15 at 9:30 A.M., E1 stated that the facility 's resident census is 34 residents. (B) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall

	population of Fability	Trouidi	~			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
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	be formulated by a	Resident Care Policy	A CONTRACTOR OF THE CONTRACTOR			
	Committee consisting	ng of at least the	The same of the sa			
	medical advisory co	dvisory physician or the ommittee, and representatives				
	of nursing and other	r services in the facility. The	PAGE PAGE PAGE PAGE PAGE PAGE PAGE PAGE			
	policies shall comple	y with the Act and this Part.				
	The written policies	shall be followed in operating				
	the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.					
	This Requirement is	not met as evidenced by:				
Based on observation, interview, and record						
	review the facility failed to secure indwelling urinary catheter tubing for two of two residents					
		ved for indwelling urinary				
	catheters in a sample					
	Tallioto o ili a campi					
	Findings include:	The company of the co				
	The facility policy on	Urinary Catheter Care dated				
	10/2010 states "Sec	cure catheter utilizing a leg				
	band."	out out local duning a log				
		10 days septimination of the second s				
		15a.m. E4 (Certified Nurse				<b>!</b>
	Aide/CNA) and E5 (0	CNA) were providing				-
į	indwelling urinary ca	theter care to R103. R103's				
(	catheter tubing was i	not secured to R103's leg				
	and was hanging free	ely between R103's legs.				
		a.m. E4 verified R103's theter tubing was not				
1	secured to R103's la	g stating, "(R103) doesn't				
1	use a leg belt or anyt	hina "				
	and a second control control		Political de Innoversion			
2	2. On 9/08/15 at 1:10	0p.m. E6 (Wound Nurse)				
a	and E7 (Certified Nur	rse Aide) were assisting				
F	R101 with cares. R1	01's indwelling urinary				
C	atheter tubing was r	not secured to R101's leg				
a	and was hanging free	ely between R101's legs.				
(	On 9/09/15 at 3:00p.r	m. E2 (Director of Nurses)				

	IIIIIOIS L	repartment of Public	neaith				
		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	***************************************		IL6012322	B. WING		09/	10/2015
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		should have the catheresidents' leg.  Section 300.1210 G Nursing and Person A regular program to sores, heat rashes of be practiced on a 24	o prevent and treat pressure or other skin breakdown shall I-hour, seven-day-a-week				
	American de la compansa de la compa	without pressure sor pressure sores unles condition demonstra were unavoidable. A sores shall receive to promote healing, pre- new pressure sores Section 300.1220 Su Services b) 3)					
		each resident based comprehensive asse and goals to be acco and personal care ar representing other se activities, dietary, and are ordered by the plothe preparation of the plan shall be in writin	on the resident's essment, individual needs emplished, physician's orders, and nursing needs. Personnel, ervices such as nursing, d such other modalities as ensident, shall be involved in the resident care plan. The g and shall be reviewed and				
		modified in keeping vindicated by the resideshall be reviewed at I Section 300.610 Resonated The facility shall have procedures governing facility. The written proper formulated by a Recommittee consisting administrator, the advantaged in the seconated to the s	vith the care needed as lent's condition. The plan east every three months. ident Care Policies a) written policies and g all services provided by the policies and procedures shall esident Care Policy				

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			UA, IL 6255	50		
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	of nursing and other policies shall comply The written policies the facility and shall	r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed				
	This requirement wa	as not met as evidenced by:				
	review the facility fai treatment orders, an pressure ulcer preve	on, interview, and record iled to prevent, obtain nd provide individualized ention interventions for one of ) reviewed for pressure ulcers				
	Findings include:					
	11/2010 states, "A strisk assessment (Braidentify residents who development of presidents of prevention with the consideration of medical consideration of medical condition and overall residents well as the each individual." The Wound Care Nurse of will conduct weekly a pressure ulcersThe include stagePhy reatment will be obtained to the conduct weekly a pressure ulcersThe include stagePhy reatment will be obtained to the care will have care Turning schedulepupport surfaces in cidents at moderate upport surfaces in cidents.	sure ulcersAn individual ill be developed to meet the t. It will include the chanical support g, mobility, continence, skin clinical condition of the risk factors as they apply to e policy also states, "The or designated licensed nurse assessments of existing e assessment should sician's orders for specific ained." The policy states that e risk of developing pressure plan interventions to include, pressure redistribution				

S9999 Continued From page 6  3/16/15 documents R103 was low risk for developing a pressure ulcer. R103's Norton Skin assessment dated 6/01/15 and 8/14/15 document R103 is at a moderate risk of developing a pressure ulcer. R103's pressure ulcer wound log documents R103's pressure ulcer wound log documents R103's right heel wound was staged as UTD (unable to determine) and was described as having a purple, scaly wound bed and edges. The pressure ulcer wound log documents include weekly wound documentation for R103's right heel between 7/01/15 and 8/05/15. R103's pressure ulcer wound log documents R103's right heel between 7/01/15 and 8/05/15. R103's pressure ulcer wound log documents R103's developed a stage two pressure ulcer to the coccyx on 7/17/15.  R103's Nurse's notes dated 5/26/15 to 7/05/15 do not include documentation R103's physician was notified of R103's right heel pressure ulcer which developed 5/26/15. Nurse's notes dated 7/17/15 to 7/20/15 document R103 did not obtain physician orders for the treatment to R103's coccyx pressure ulcer until 7/20/15,	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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3/16/15 documents R103 was low risk for developing a pressure ulcer. R103's Norton Skin assessment dated 6/01/15 and 8/14/15 document R103 is at a moderate risk of developing a pressure ulcer.  R103's pressure ulcer wound log documents R103's pressure ulcer wound log documents R103's pressure ulcer wound log documents R103's right heel wound was staged as UTD (unable to determine) and was described as having a purple, scaly wound bed and edges. The pressure ulcer wound log does not include weekly wound documentation for R103's right heel between 7/01/15 and 8/05/15. R103's pressure ulcer wound log also documents R103 developed a stage two pressure ulcer to the coccyx on 7/17/15.  R103's Nurse's notes dated 5/26/15 to 7/05/15 do not include documentation R103's physician was notified of R103's right heel pressure ulcer which developed 5/26/15. Nurse's notes dated 7/17/15 to 7/20/15 document R103 did not obtain physician orders for the treatment to R103's coccyy pressure ulcer until 7/20/15,	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
developing a pressure ulcer. R103's Norton Skin assessment dated 6/01/15 and 8/14/15 document R103 is at a moderate risk of developing a pressure ulcer. R103's pressure ulcer wound log documents R103 developed a pressure ulcer to the right heel on 5/26/15. The wound log documents R103's right heel wound was staged as UTD (unable to determine) and was described as having a purple, scaly wound bed and edges. The pressure ulcer wound log does not include weekly wound documentation for R103's right heel between 7/01/15 and 8/05/15. R103's pressure ulcer wound log also documents R103 developed a stage two pressure ulcer to the coccyx on 7/17/15. R103's Nurse's notes dated 5/26/15 to 7/05/15 do not include documentation R103's physician was notified of R103's right heel pressure ulcer which developed 5/26/15. Nurse's notes dated 7/17/15 to 7/20/15 document R103 did not obtain physician orders for the treatment to R103's coccyx pressure ulcer until 7/20/15,	S9999	Continued From pa	ge 6	S9999			
R103's physician's orders (POS) document R103 did not receive treatment orders for the stage two coccyx pressure ulcer until 7/20/15. R103's POS documents R103 did not receive a physician's ordered treatment for the right heel pressure ulcer which developed 5/26/15 until 8/07/15. R103's treatment administration record (TAR) dated 7/2015 documents a physician ordered treatment to R103's coccyx pressure ulcer which developed 7/17/15 which did not begin until 7/20/15. R103's TAR dated 8/2015 documents a physician ordered treatment to R103's right heel which did not begin until 8/07/15. R103's pressure ulcer care plan dated 6/10/15 documents R103 has the potential for skin		3/16/15 documents developing a pressur assessment dated 6 R103 is at a modera pressure ulcer. R103's pressure ulcer. R103's pressure ulcer. R103 developed a pon 5/26/15. The woright heel wound wadetermine) and was purple, scaly wound pressure ulcer wound documentatic between 7/01/15 and ulcer wound log also a stage two pressure 7/17/15. R103's Nurse's note not include document include document include document include document for coccyx pressure ulcer coccyx pressure ulcer documents R103's physician orders for coccyx pressure ulcer documents R103 did ordered treatment foulcer which developed R103's treatment and dated 7/2015 document to R103's treatment and dated 7/2015. R103's TAF physician ordered trewhich did not begin un R103's pressure ulcer which did not begin un R103'	R103 was low risk for ure ulcer. R103's Norton Skin 6/01/15 and 8/14/15 document atterisk of developing a ser wound log documents pressure ulcer to the right heel and log documents R103's staged as UTD (unable to described as having a bed and edges. The and log does not include weekly on for R103's right heel d 8/05/15. R103's pressure of documents R103 developed the ulcer to the coccyx on the stage to the described as having a bed and edges. The and log does not include weekly on for R103's right heel d 8/05/15. R103's pressure of documents R103 developed the ulcer to the coccyx on the stage to the stage two per until 7/20/15, and the treatment to R103's processor and the treatment to R103's processor and the stage two per until 7/20/15. R103's POS of not receive a physician's are the right heel pressure and 5/26/15 until 8/07/15. In ministration record (TAR) ents a physician ordered coccyx pressure ulcer which which did not begin until R dated 8/2015 documents a certain to R103's right heel until 8/07/15. For care plan dated 6/10/15	S9999			

Illinois Department of Public Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	R103 had met the g of 6/10/15. R103's of documents R103 had to the coccyx with the checks weekly, treat and document week and symptoms of infishift. R103's care please specific pressure ulcontent interventions such a surfacespositioning condition and overall resident. R103's Minimum Dates assistance of two petransfers. On 9/08/15 at 11:15a wheelchair in R103's Nurse Aides) applied using extensive assistante of two petransfers. Wound Nurse) begand coccyx pressure (Wound Nurse) begand coccyx pressure measured R103's rig (centimeters) long x (cand noted the wound color. E6 stated R10 unstageable pressure coccyx dressing and wound as 1.0cm wide and noted the wound wound bed. E6 state stage two pressure ulcon 9/09/15 at 12:00p Coordinator) stated Eassessment to measure and second to measure the stage two pressure ulcon 9/09/15 at 12:00p Coordinator) stated Eassessment to measure and coccyx dressing and coccyx of the wound wound bed. E6 state stage two pressure ulcon 9/09/15 at 12:00p Coordinator) stated Eassessment to measure and coccyx with the coccyx of the wound wound bed. E6 state stage two pressure ulcon 9/09/15 at 12:00p Coordinator) stated Eassessment to measure and coccyx with the coccyx of the wound wound bed. E6 state stage two pressure ulcon 9/09/15 at 12:00p Coordinator) stated Eassessment to measure and coccyx with the checks with the coccyx	S's care plan documents that oal of no skin breakdown as care plan dated 7/20/15 is a stage two pressure ulcer interventions of: skin timent as ordered, measure ally, notify physician if signs fection, and monitor every lan does not include resident the relief/prevention as mechanical support and general condition of the last assessment dated R103 requires extensive ople for bed mobility and last agait belt to R103 then stance, transferred R103 iss on R103's bed. Earn changing R103's right heel ulcer dressings. Earn changing R103's coccyx is x 1.0cm long x 0.0cm deep bed had a pinkish tand d R103's coccyx wound is a locer.  In E8 (Care Plan 8 performed the Norton skin ure R103's risk of	S9999				
d	leveloping pressure ι	llcers. E8 verified R103 developing a pressure ulcer			TOTAL TOTAL		

Illinois Department of Public Health

4D1X11

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6012322 09/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **525 SOUTH MACON STREET MOWEAQUA REHAB & HCC** MOWEAQUA, IL 62550 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 8 S9999 on the 3/16/15 assessment. E8 also verified R103 was assessed as a moderate risk of developing a pressure ulcer on the 6/01/15 and 8/14/15 assessments despite having two pressure ulcers at the time of the assessments. E8 verified R103's care plan did not include resident specific measures for prevention or treatment of pressure ulcers once R103 developed a stage two pressure ulcer to the coccyx. E8 verified R103 did not have a pressure reducing mattress added to R103's bed as a pressure reduction measure. E8 stated staff turn and reposition R103 every two hours. E8 verified R103's care plan did not include interventions for turning and repositioning. On 9/09/15 at 3:00p.m. E2 (Director of Nurses) stated the facility had no documentation R103 had been turned and repositioned prior to approximately one week ago. E2 stated the facility had just started documenting when residents are turned and repositioned. (B) Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to

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the facility.

This requirement is not met as evidenced by:

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6012322		B. WING		09/	10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 001	10/2013
MOWEA	QUA REHAB & HCC	525 SOU <sup>-</sup>	TH MACON	STREET		
	· ·		QUA, IL 625	50		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 9	S9999			
	review the facility fa medications from be two residents (R103 administration on a	on, interview, and record iled to prevent incorrect eing administered to one of eviewed for medication sample of five, and two 11) on the supplemental				
	Findings include:					
	dated 12/2012 states administered in account of the state administered in account of the state administeres was administed with the state administered administered two tab physician's order (PC prescribed Oyster Strutamin D 200 IU one	ering Medications policy s, "Medications must be ordance with the orders" 40p.m. E2 (Director of stering medications to R103. of Oyster Shell calcium with Vitamin D 125 IU from the medication cart then slets to R103. R103's DS) documents R103's was nell calcium 500mg with e tablet two times daily.				
	medications to R110. Calcium 600mg with medication cart then R110. R110's physic	55p.m. E2 was administering E2 withdrew a bottle of Vitamin D 400 IU from the administered one tablet to ian's order documents R110 um 600mg one tablet without				
N E V	Nurse) was administe E3 withdrew a bottle of Vitamin D 800 IU fron administered one tabl ohysician's order doc	uments R111 was 00mg one tablet without				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION :		SURVEY PLETED
				* ************************************		
٥		IL6012322	B. WING		09/	10/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MOWEA	QUA REHAB & HCC		H MACON S			
			UA, IL 625	50		
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S9999	Continued From page	ge 10	S9999			
	physician order for the addition of Vitan	Calcium 600mg do not include nin D to the calcium. (B)				
	in his or her medical Every resident's cas examination and tre and shall be conduct persons not directly must have his or her (Section 2-105 of the This requirement is a Based on observation review the facility fail visual privacy during	permitted respect and privacy and personal care program. The discussion, consultation, atment shall be confidential ted discreetly, and those involved in the resident's care remission to be present.				
	of five. Findings include:					
	10/2009 states, "State and protect resident privacy during assisted during treatment producing treatment produced by the covernation of the covern	f Life-Dignity policy dated ff shall promote, maintain privacy, including bodily ance with personal care and cedures." m. E6 (Wound Nurse) was d wound assessment to ned to the side facing the rs which exposed R101's vaist down. E7 (Certified the door to R101's room 's nude body from the waist m. E2 (Director of Nurses) naintain residents' bodily hal care by closing doors and				

PRINTED: 10/14/2015 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6012322 09/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **525 SOUTH MACON STREET** MOWEAQUA REHAB & HCC MOWEAQUA, IL 62550 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 11 S9999 privacy curtains to prevent exposing the residents' body to the hallway.